		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0013896

Facility Name: St Matthew Lutheran Home

Address: 1601 N. Western Ave. (Number) Park Ridge (City) 60068 (Zip Code)

County: Cook

Telephone Number: (847) 825-5531 **Fax #** (847) 318-6659

IDPA ID Number: 36-2584799-001

Date of Initial License for Current Owners: 1959

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (C) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Dorkas Cruz **Telephone Number:** (847) 635-4633

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Frederick Aigner
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 176

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	176	64,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		28,103	4,005	32,108	8
9	SNF/PED	14,286			14,286	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,286	28,103	4,005	46,394	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.22%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1959

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 4,005

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/01 Fiscal Year: 6/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	305,229	27,768	78,791	411,788		411,788		411,788			1
2	Food Purchase		257,963		257,963		257,963	(1,828)	256,135			2
3	Housekeeping	96,555	52,918		149,473		149,473		149,473			3
4	Laundry	44,021	67,727	26,278	138,026		138,026		138,026			4
5	Heat and Other Utilities			196,617	196,617	2,018	198,635		198,635			5
6	Maintenance	79,238	10,606	79,283	169,127	4,531	173,658		173,658			6
7	Other (specify):* **Rubish Removal**			14,369	14,369	815	15,184		15,184			7
8	**TOTAL General Services**	525,043	416,982	395,338	1,337,363	7,364	1,344,727	(1,828)	1,342,899			8
	B. Health Care and Programs											
9	Medical Director			15,800	15,800		15,800		15,800			9
10	Nursing and Medical Records	2,428,059	325,113	62,989	2,816,161		2,816,161		2,816,161			10
10a	Therapy	43,814		141,317	185,131		185,131		185,131			10a
11	Activities	79,766	5,225	11,755	96,746		96,746		96,746			11
12	Social Services	171,919	545	1,026	173,490		173,490		173,490			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Dentist & pers.Suppl.**			2,560	2,560		2,560	(1,030)	1,530			15
16	**TOTAL Health Care and Programs**	2,723,558	330,883	235,447	3,289,888		3,289,888	(1,030)	3,288,858			16
	C. General Administration											
17	Administrative	66,410			66,410	171,830	238,240		238,240			17
18	Directors Fees											18
19	Professional Services			574,898	574,898	(354,442)	220,456	65,198	285,654			19
20	Dues, Fees, Subscriptions & Promotions			38,037	38,037	27,353	65,390	(18,530)	46,860			20
21	Clerical & General Office Expenses	145,833	21,562	56,458	223,853	38,173	262,026		262,026			21
22	Employee Benefits & Payroll Taxes			707,542	707,542	30,333	737,875		737,875			22
23	Inservice Training & Education					5,210	5,210		5,210			23
24	Travel and Seminar			14,460	14,460		14,460	(928)	13,532			24
25	Other Admin. Staff Transportation					7,183	7,183		7,183			25
26	Insurance-Prop.Liab.Malpractice			22,732	22,732	9,553	32,285	(6,525)	25,760			26
27	Other (specify):* **Marketing, Fundraisi**	5,086			5,086	4,255	9,341	(9,341)				27
28	**TOTAL General Administration**	217,329	21,562	1,414,127	1,653,018	(60,552)	1,592,466	29,874	1,622,340			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,465,930	769,427	2,044,912	6,280,269	(53,188)	6,227,081	27,016	6,254,097			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Matthew Lutheran Home #0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			374,475	374,475	23,704	398,179	(4,114)	394,065			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			195,386	195,386	6,107	201,493	(351)	201,142			32
33	Real Estate Taxes					177	177		177			33
34	Rent-Facility & Grounds					21,179	21,179		21,179			34
35	Rent-Equipment & Vehicles			39,997	39,997	2,021	42,018		42,018			35
36	Other (specify):*											36
37	**TOTAL Ownership**			609,858	609,858	53,188	663,046	(4,465)	658,581			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			277	277		277		277			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,708	96,708		96,708		96,708			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			96,985	96,985		96,985		96,985			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,465,930	769,427	2,751,755	6,987,112		6,987,112	22,551	7,009,663			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,828)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,565)	30		9
10	Interest and Other Investment Income	(351)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,341)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	37,239			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 23,154		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(603)	30	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (603)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 22,551		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Matthew Lutheran Home

ID# **0013896**

Report Period Beginning: **07/01/00**

Ending: **06/30/01**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Allowable Mgmt & HR Alloc	$ 63,568	19	1
2	Allowable Service Network Allocation	1,630	19	2
3	Awards & Grants	162	20	3
4	Out of State Travel & Seminar	(928)	24	4
5	Management auto Depreciation	(946)	30	5
6	Insurance Premium overpayment against exp.	(6,525)	26	6
7	Clothing & Personal Supplies	(1,030)	15	7
8	Adv & Promotion Pgm	(18,692)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	37,239		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Matthew Lutheran Home # 0013896 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,828)	0	0	0	0	0	0	0	0	0	0	(1,828)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,828)	0	0	0	0	0	0	0	0	0	0	(1,828)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(1,030)	0	0	0	0	0	0	0	0	0	0	(1,030)	15
16	**TOTAL Health Care and Programs**	(1,030)	0	0	0	0	0	0	0	0	0	0	(1,030)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	65,198	0	0	0	0	0	0	0	0	0	0	65,198	19
20	Fees, Subscriptions & Promotions	(18,530)	0	0	0	0	0	0	0	0	0	0	(18,530)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(928)	0	0	0	0	0	0	0	0	0	0	(928)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(6,525)	0	0	0	0	0	0	0	0	0	0	(6,525)	26
27	Other (specify):*	(9,341)	0	0	0	0	0	0	0	0	0	0	(9,341)	27
28	**TOTAL General Administration**	29,874	0	0	0	0	0	0	0	0	0	0	29,874	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	27,016	0	0	0	0	0	0	0	0	0	0	27,016	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **St Matthew Lutheran Home** **#** **0013896** **Report Period Beginning:** **07/01/00** **Ending:** **06/30/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,114)	0	0	0	0	0	0	0	0	0	0	(4,114)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(351)	0	0	0	0	0	0	0	0	0	0	(351)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,465)	0	0	0	0	0	0	0	0	0	0	(4,465)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	22,551	0	0	0	0	0	0	0	0	0	0	22,551	45

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Vesper Mgmt Corp.	Des Plaines Il	Mgmt Co.
				LSSI	Des Plaines Il	Corp. Office
N/A	N/A	N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Matthew Lutheran Home # 0013896 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Lutheran Social Services of Illinois
Street Address 1001 E. Touhy Ave Suite # 50
City / State / Zip Code Des Plaines Il. 60018
Phone Number (847)-635-4600
Fax Number (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	27,215,384	270	$ 1,056,638	$ 1,056,638	1,706,589	$ 66,258	1
2	22	Empl Benefits & Taxes		27,215,384		218,957		1,706,589	13,730	2
3	19	Prof Fees & Contracts		27,215,384		3,715,943		1,706,589	233,015	3
4	21	Supplies, Telephone,		27,215,384		535,066		1,706,589	33,552	4
5		Postage, Out. Printing		27,215,384		0		1,706,589	0	5
6	34	Rental of Space		27,215,384		326,694		1,706,589	20,486	6
7	5	Utilities		27,215,384		31,566		1,706,589	1,979	7
8	6	Bldg Repairs & Maintenance		27,215,384		(80)		1,706,589	(5)	8
9	32	Interest		27,215,384		82,750		1,706,589	5,189	9
10	33	Real Estate Taxes		27,215,384		2,822		1,706,589	177	10
11	26	Insurance		27,215,384		151,003		1,706,589	9,469	11
12	27	Advertising & Promotions		27,215,384		49,466		1,706,589	3,102	12
13	25	Transportation		27,215,384		47,462		1,706,589	2,976	13
14	35	Car Rental		27,215,384		5,970		1,706,589	374	14
15	23	Conferences & Conventions		27,215,384		51,384		1,706,589	3,222	15
16	20	Subscriptions, Dues, Awards		27,215,384		64,832		1,706,589	4,065	16
17	21	Furniture & Fixtures		27,215,384		1,593		1,706,589	100	17
18	6	Machinery & Equipment		27,215,384		182		1,706,589	11	18
19	35	Equipment Rental		27,215,384		9,115		1,706,589	572	19
20	6	Equipment Repair & Maint.		27,215,384		67,869		1,706,589	4,256	20
21	20	Employee Recruitment		27,215,384		28,122		1,706,589	1,763	21
22	7	Security & Waste Removal		27,215,384		12,998		1,706,589	815	22
23	21	All Other Miscellaneous		27,215,384		4,405		1,706,589	276	23
24	30	Depreciation		27,215,384		337,778		1,706,589	21,181	24
25	TOTALS					$ 6,802,535	$ 1,056,638		$ 426,563	25

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave Suite # 50
City / State / Zip Code: Des Plaines Il. 60018
Phone Number: (847)-635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Salaries & Benefits	44,347,970	270	$ 730,935	$ 730,935	4,176,137	$ 68,830	1
2	22	Empl Benefits & Taxes		44,347,970		96,673		4,176,137	9,103	2
3	19	Prof Fees & Contracts		44,347,970		123,952		4,176,137	11,672	3
4	21	Supplies, Telephone,		44,347,970		44,417		4,176,137	4,183	4
5		Postage, Out. Printing		44,347,970				4,176,137		5
6	34	Rental of Space		44,347,970		7,359		4,176,137	693	6
7	5	Utilities		44,347,970		409		4,176,137	39	7
8	6	Bldg Repairs & Maintenance		44,347,970		658		4,176,137	62	8
9	32	Interest		44,347,970		4,700		4,176,137	443	9
10	33	Real Estate Taxes		44,347,970				4,176,137		10
11	26	Insurance		44,347,970		888		4,176,137	84	11
12	27	Advertising & Promotions		44,347,970				4,176,137		12
13	25	Transportation		44,347,970		22,753		4,176,137	2,143	13
14	35	Car Rental		44,347,970		2,024		4,176,137	191	14
15	23	Conferences & Conventions		44,347,970		8,477		4,176,137	798	15
16	20	Subscriptions, Dues, Awards		44,347,970		208,560		4,176,137	19,640	16
17	21	Furniture & Fixtures		44,347,970		22		4,176,137	2	17
18	6	Machinery & Equipment		44,347,970				4,176,137		18
19	35	Equipment Rental		44,347,970		9,388		4,176,137	884	19
20	6	Equipment Repair & Maint.		44,347,970		2,201		4,176,137	207	20
21	20	Employee Recruitment		44,347,970		18,345		4,176,137	1,728	21
22	7	Security & Waste Removal		44,347,970				4,176,137		22
23	21	All Other Miscellaneous		44,347,970		4,517		4,176,137	425	23
24	30	Depreciation		44,347,970		18,595		4,176,137	1,751	24
25	TOTALS					$ 1,304,873	$ 730,935		$ 122,878	25

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave Suite # 50
City / State / Zip Code: Des Plaines Il. 60018
Phone Number: (847)-635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	4,523,542	2	$ 97,390	$ 97,390	1,706,589	$ 36,742	1
2	22	Empl Benefits & Taxes		4,523,542		19,879		1,706,589	7,500	2
3	19	Prof Fees & Contracts		4,523,542		1,301		1,706,589	491	3
4	21	Supplies, Telephone,		4,523,542		3,617		1,706,589	1,365	4
5		Postage, Out. Printing		4,523,542				1,706,589		5
6	34	Rental of Space		4,523,542				1,706,589		6
7	5	Utilities		4,523,542				1,706,589		7
8	6	Bldg Repairs & Maintenance		4,523,542				1,706,589		8
9	32	Interest		4,523,542		1,259		1,706,589	475	9
10	33	Real Estate Taxes		4,523,542				1,706,589		10
11	26	Insurance		4,523,542				1,706,589		11
12	27	Advertising & Promotions		4,523,542		3,057		1,706,589	1,153	12
13	25	Transportation		4,523,542		5,471		1,706,589	2,064	13
14	35	Car Rental		4,523,542				1,706,589		14
15	23	Conferences & Conventions		4,523,542		3,153		1,706,589	1,190	15
16	20	Subscriptions, Dues, Awards		4,523,542		415		1,706,589	157	16
17	21	Furniture & Fixtures		4,523,542				1,706,589		17
18	6	Machinery & Equipment		4,523,542				1,706,589		18
19	35	Equipment Rental		4,523,542				1,706,589		19
20	6	Equipment Repair & Maint.		4,523,542				1,706,589		20
21	20	Employee Recruitment		4,523,542				1,706,589		21
22	7	Security & Waste Removal		4,523,542				1,706,589		22
23	21	All Other Miscellaneous		4,523,542		(4,585)		1,706,589	(1,730)	23
24	30	Depreciation		4,523,542		2,045		1,706,589	772	24
25	TOTALS					$ 133,002	$ 97,390		$ 50,179	25

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax Exempt Bonds		X	Refinance Building Additions	N/A	9/23/93	$ 1,286,188	$ 2,727,837	8/15/20	0.0738	$ 195,386	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mgmt Allocation	X		Management Allocation	N/A	N/A	N/A	N/A	N/A	N/A	6,107	6
7												7
8												8
9	TOTAL Facility Related						$ 1,286,188	$ 2,727,837			$ 201,493	9
	B. Non-Facility Related*											
10												10
11	Interest Income			Offset against interest expense	N/A	N/A	N/A	N/A	N/A	N/A	(351)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (351)	14
15	TOTALS (line 9+line14)						$ 1,286,188	$ 2,727,837			$ 201,142	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Matthew Lutheran Home # 0013896 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Matthew Lutheran Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0013896

CONTACT PERSON REGARDING THIS REPORT Dorkas Cruz

TELEPHONE (847) 635-4633 FAX #: (847) 635-5764

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ N/A
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ N/A	$ N/A

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,590 B. General Construction Type: Exterior Mazonry Frame Steel Beam Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	203,354	1958	$ 38,704	1
2					2
3	TOTALS	203,354		$ 38,704	3

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1959	1959	$ 444,500	$	40	$	$	$ 444,500	4
5			1966	1966	315,066	7,877	40	7,877		279,675	5
6	176		1976	1976	2,205,040	55,126	40	55,126		1,405,789	6
7			1976	1976	24,547	614	40	614		15,352	7
8			1977	1977	13,438	336	40	336		8,231	8
	Improvement Type**										
9	1983 Addition			1983	150,179		10			150,179	9
10	1978 Addition			1978	1,780		10			1,780	10
11	1979 Addition			1979	5,380		10			5,380	11
12	1983 Addition			1983	2,142		10			2,142	12
13	1984 Addition			1984	11,139		10			11,139	13
14	1985 Addition			1985	2,400		10			2,400	14
15	1986 Addition			1986	7,692		10			7,692	15
16	1987 Addition			1987	291,787	14,589	20	14,589		211,566	16
17	Renovations			1989	268,451		10			268,451	17
18	ADJUSTMENT PER IDPA - 1989 Renovations			1989	(22,714)		10			(22,714)	18
19	ADJUSTMENT PER IDPA - 1988 Costs			1988	14,914		10			14,914	19
20	Aluminum Awning			1990	1,400		10			1,400	20
21	Canopy / Western ave.			1992	30,720	1,228	25	1,228		11,679	21
22	Panasonic Camera System			1992	3,720		5			3,720	22
23	New Sidewalk			1992	2,500	250	10	250		2,442	23
24	Concrete Loading dock			1992	6,690	669	10	669		6,444	24
25	Bathroom Remodeling			1992	13,440	1,344	10	1,344		11,430	25
26	Chapel Renovation			1992	33,385	3,338	10	3,338		28,381	26
27	Generator & Mechanical Work			1993	43,564	4,356	10	4,356		32,691	27
28	New Roof West Building			1993	208,807	20,881	10	20,881		156,691	28
29	Generator Projct & electrical			1993	146,296	14,630	10	14,630		109,782	29
30	Upgrade West Building Electrical			1993	19,029	1,903	10	1,903		14,280	30
31	Alzeheimer Unit			1992	40,114	4,011	10	4,011		30,102	31
32	Alzeheimer Unit			1993	35,728	3,573	10	3,573		26,811	32
33	ADJUSTMENT PER IDPA - Alzeheimer Unit			1993	(6,025)		10	(603)	(603)	(4,824)	33
34	ADJUSTMENT PER IDPA - 1990 Improvements OHF			1990	19,450		10			19,450	34
35	Parking Lot Lighting			1994	17,300	1,730	10	1,730		12,977	35
36	Shower Room Renovation			1994	9,455	945	10	945		6,149	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Rehab Area Renovation	1994	$ 55,583	$ 5,558	10	$ 5,558	$	$ 36,152	37
38	Air Conditioning - West Bldg	1995	32,823	3,282	10	3,282		20,359	38
39	Air Conditioning Project - #95-056	1995	5,423	542	10	542		3,007	39
40	ADA Elevator Upgrade	1996	5,548	555	10	555		3,052	40
41	Air Conditioner - Laudry Room	1997	842	84	10	84		315	41
42	Fence & Installation	1997	674	67	10	67		253	42
43	Kitchen A/C & Installation	1997	17,500	2,501	7	2,501		9,373	43
44	Installation of Fire Doors	1997	4,897	196	25	196		701	44
45	Landscape Materials	1998	1,600	160	10	160		507	45
46	Retainers - Int. Design	1998	3,085	308	10	308		925	46
47	Interior Design Fees	1998	1,349	135	10	135		382	47
48	Interior Design Fees	1998	3,000	300	10	300		849	48
49	Construction Project	1998	11,282	1,128	10	1,128		3,004	49
50	Painting & Staining	1998	13,725	1,373	10	1,373		3,655	50
51	Painting & Staining	1998	13,723	1,372	10	1,372		3,655	51
52	HVAC/Electrical Upgrade	1998	6,482	648	10	648		1,673	52
53	1998 Addition	1998	170,700	6,828	25	6,828		19,904	53
54	Wall & Door Install - Décor	1999	2,850	285	10	285		665	54
55	Architecture, Electrical	1998	10,602	1,060	10	1,060		2,475	55
56	Windw Replacement	1998	4,765	476	10	476		1,112	56
57	Energy Study & Admin	1998	1,948	195	10	195		455	57
58	HVAC & Admin	1998	3,325	332	10	332		776	58
59	Carpet Installation	1999	125,765	12,584	10	12,584		28,294	59
60	MDC Wallcovering	1998	4,400	440	10	440		990	60
61	Add-Ons for Lobby Window	1999	1,800	180	10	180		405	61
62	Install Wood Veener	1999	894	89	10	89		201	62
63	Paint Sprinkler Pipes	1999	120	12	10	12		27	63
64	Air Conditioning	1999	446	18	25	18		37	64
65	Glass repair - bldg décor project	1999	2,659	266	10	266		532	65
66	Remodel 6 resident rooms	1999	720	72	10	72		144	66
67	120L/F/Roppe & Johnson	1999	170	17	10	17		34	67
68	Installation of Awnings	1999	8,307	831	10	831		1,381	68
69	Couch Wallcovering	1999	61	6	10	6		9	69
70	TOTAL (lines 4 thru 69)		$ 4,878,383	$ 179,300		$ 178,697	$ (603)	$ 3,421,384	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,878,383	$ 179,300		$ 178,697	$ (603)	$ 3,421,384	1
2	Installation of Awnings	2000	241	24	10	24		34	2
3	Installation of new windows	2000	35,200	3,520	10	3,520		4,687	3
4	Electric Upgrade	2000	16,253	3,251	5	3,251		3,509	4
5	2000 Addition	2000	49,564	4,956	10	4,956		5,350	5
6	Door to laundry	2000	5,995	598	10	598		598	6
7	Furniture & Flooring	2001	341,679	34,074	10	34,074		34,074	7
8	Cable tv system	2001	15,169	1,513	10	1,513		1,513	8
9	Awning Installation	2001	235,000	23,436	10	23,436		23,436	9
10	Exahust Fans Replacement	2001	6,055	604	10	604		604	10
11	Air Conditioning Project	2001	88	4	25	4		4	11
12	Air Conditioning project	2001	107,325	4,281	25	4,281		4,281	12
13	Air Conditioning project	2001	253,678	10,119	25	10,119		10,119	13
14	Signs Internally V Shaped	2001	20,570	2,051	10	2,051		2,051	14
15	Air Conditioning project	2001	147,096	4,868	25	4,868		4,868	15
16	Installation of private Cable System	2001	15,170	1,255	10	1,255		1,255	16
17	Seal Coating- St	2001	5,150	170	10	170		170	17
18	Boiler Set Up	2001	214,651	7,104	25	7,104		7,104	18
19	Facility Upgrades	2001	1,509	112	10	112		112	19
20	Facility Upgrades	2001	774	58	10	58		58	20
21	St Matts Air Conditioning	2001	78,348	2,069	25	2,069		2,069	21
22	Windows & Screen Replacement	2001	1,683	97	10	97		97	22
23	Facility Upgrades Cable	2001	5,467	316	10	316		316	23
24	Air Conditioning Project	2001	4,715	93	25	93		93	24
25	Air Conditioning Project	2001	11,400	186	25	186		186	25
26	Door Alarm System	2001	1,452	69	7	69		69	26
27	Garbage Disposers	2001	3,512	87	10	87		87	27
28	Install chilled water cooler	2001	103,301	328	25	328		328	28
29	Fix Door and Wall	2000	3,280	131	25	131		142	29
30	Update Fire Panel	2001	7,051	56	10	56		56	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,569,759	$ 284,730		$ 284,127	$ (603)	$ 3,528,654	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,569,759	$ 284,730		$ 284,127	$ (603)	$ 3,528,654	1
2	FY 89 IDPA Audit - Phone System Amplifiers	1989	491		5			491	2
3	FY 89 IDPA Audit - Garbage Disposer	1989	2,654		5			2,654	3
4	FY 89 IDPA Audit - Ceiling Fans	1989	2,724		7			2,724	4
5	FY 89 IDPA Audit - Toilet Frames	1989	734		5			734	5
6	FY 89 IDPA Audit - Air Conditioner	1989	993		5			993	6
7	Management Assets - Security System	1999	271		10	61	61	N/A	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,577,626	$ 284,730		$ 284,188	$ (542)	$ 3,536,250	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 760,732	$ 69,778	$ 90,675	$ 20,897	Various	$ 280,637	71
72	Current Year Purchases	86,154	9,599	11,398	1,799	Various	9,599	72
73	Fully Depreciated Assets	457,903				Various	457,903	73
74								74
75	TOTALS	$ 1,304,789	$ 79,377	$ 102,073	$ 22,696		$ 748,139	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transp.	1997 Champion Challenger	1997	$ 54,610	$ 10,369	$ 7,804	$ (2,565)	7	$ 29,248	76
77										77
78										78
79										79
80	TOTALS			$ 54,610	$ 10,369	$ 7,804	$ (2,565)		$ 29,248	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,975,729	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 374,476	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 394,065	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 19,589	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,313,637	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1990 Dodge Caravan 1990	$ 13,609	$	$ 13,609	86
87	Truck Cover 1988	775		775	87
88	1988 Dodge Sweptline P.U.	10,040		10,040	88
89	Management Autos	7,959	946	N/A	89
90	1990 Ford Paratransit Van 1990	36,850		36,850	90
91	TOTALS	$ 69,233	$ 946	$ 61,274	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 26,271 Description: Copy Machine rental, Beds, Mattress, Postage Meter Machine
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Nurses are trained prior to being hired.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	N/A			
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	N/A
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits	N/A						6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Matthew Lutheran Home **#** 0013896 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$	48

***(See instructions.)**

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,560,753	1
2	Discounts and Allowances for all Levels	(90,602)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,470,151	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,539	14
15	Telephone, Television and Radio	380	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,919	23
	D. Non-Operating Revenue		
24	Contributions	22,163	24
25	Interest and Other Investment Income***	351	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,514	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Sales of cookies made by residents	945	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 945	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,500,529	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,337,363	31
32	Health Care	3,289,888	32
33	General Administration	1,653,018	33
	B. Capital Expense		
34	Ownership	609,858	34
	C. Ancillary Expense		
35	Special Cost Centers	277	35
36	Provider Participation Fee	96,708	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,987,112	40
41	**Income before Income Taxes (line 30 minus line 40)****	513,417	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 513,417	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,288	2,631	$ 72,394	$ 27.52	1
2	Assistant Director of Nursing	10,100	11,105	111,775	10.07	2
3	Registered Nurses	46,899	52,984	961,647	18.15	3
4	Licensed Practical Nurses	54,670	62,063	725,362	11.69	4
5	Nurse Aides & Orderlies	46,811	51,081	527,501	10.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,181	3,816	45,155	11.83	8
9	Activity Director	4,201	4,981	79,242	15.91	9
10	Activity Assistants					10
11	Social Service Workers	8,247	9,019	128,077	14.20	11
12	Dietician					12
13	Food Service Supervisor	5,215	5,944	81,548	13.72	13
14	Head Cook	5,412	6,096	49,116	8.06	14
15	Cook Helpers/Assistants	21,899	23,487	174,565	7.43	15
16	Dishwashers					16
17	Maintenance Workers	5,078	5,703	79,238	13.89	17
18	Housekeepers	12,312	13,179	96,555	7.33	18
19	Laundry	4,454	5,104	44,021	8.62	19
20	Administrator					20
21	Assistant Administrator	1,742	2,015	66,410	32.96	21
22	Other Administrative	1,923	2,233	39,286	17.59	22
23	Office Manager					23
24	Clerical	9,143	10,035	106,547	10.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,334	3,546	29,381	8.29	31
32	Other Health Care(specify)					32
33	Other(specify)	1,924	2,162	48,110	22.25	33
34	TOTAL (lines 1 - 33)	248,833	277,184	$ 3,465,930 *	$ 12.50	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 69,684	1,3	35
36	Medical Director	As Needed	15,800	9,3	36
37	Medical Records Consultant	As Needed	12,116	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	4,200	10,3	39
40	Physical Therapy Consultant	As Needed	92,245	10A,3	40
41	Occupational Therapy Consultant	As Needed	18,553	10A,3	41
42	Respiratory Therapy Consultant	As Needed	17,053	10A,3	42
43	Speech Therapy Consultant	As Needed	15,562	10A,3	43
44	Activity Consultant	As Needed	2,847	10A,3	44
45	Social Service Consultant				45
46	Other(specify) (See Attached)	As Needed	63,102	Various	46
47	Legal & Audit/Accounting	As Needed	39,970	19,3	47
48	Laundry Services	As Needed	25,903	4,3	48
49	TOTAL (lines 35 - 48)		$ 377,035		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Carter	Administrator	0	$ 35,773
Gerrianne Dathe	Administrator	0	30,637
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,410

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RSM MCGladrey Inc	Medicare Cost Report Prep	$ 16,056
Frost Ruttenberg and Roth	Medicare Consultant	8,050
Freeman, Freeman & Salzman	Legal Fees	6,154
Marvwedel, Minichelo & Ree	Legal Fees	2,771
Transworld	Collection Services	506
Littler Mendelson	Legal Fees	1,806
John Satter	Legal Fees	1,840
Duane, Morris & Heckscher	Legal Fees	3,293
LSSI	Management Services	534,422
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 574,898

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 109,131
Unemployment Compensation Insurance	31,726
FICA Taxes	255,042
Employee Health Insurance	380,260
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	(68,617)
Management Allocation Benefits	30,333
TOTAL (agree to Schedule V, line 22, col.8)	$ 737,875

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,539
Health Care Worker Background Check	
(Indicate # of checks performed)	
Licenses & fees	0
Advertising & Promotion, Awards, Grants	18,530
Subscriptions & Books	1,215
Membership Dues	9,753
Management Allocation	27,353
Less: Public Relations Expense	( )
Non-allowable advertising	(18,530)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,860

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 928
In-State Travel	
Vehicle Operating Cost	723
Employee Mileage Payments	5,983
Meals, Lodging	(893)
Seminar Expense	3,444
Conference & Convention	2,775
Agency Meetings	1,500
Out of State Travel & Seminar	(928)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,532

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10	N/A												
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Matthew Lutheran Home # 0013896 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Life Services Network $ 5,544**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **49,431** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **96,708**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **6,539**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **CLIFTON GUNDERSON, LLC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **In progress, will send when available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.